Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
FONDREN ORTHOPEDIC GROUP LLP

Respondent Name
NATIONAL UNION FIRE INS CO OF PITTSBURG PA

MFDR Tracking Number
M4-14-2679-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
MAY 1, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have received your payment for codes 27447/22/RT on the main surgeon and the assistant and are not arguing that the payment was not the contractual amount. However, we are asking there to be a consideration for additional payment in addition to the allowed amount for the use of the 22 modifier (complex case). **The surgeons did bill with the 22 modifier to indicate that the services they had provided were greater than that usually required for the listed procedure**…***The physician has noted in the operative report that the modifier 22 was used because patient had an altered surgical field die to a significant valgus deformity with significant rotational abnormality. And the surgical procedure took over two time of the usual time amount required for this procedure***."

Amount in Dispute: $1,688.15

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier has paid per applicable fee guidelines. Please see the EOBs provided as part of the requestor's filing and/or attached hereto…the carrier challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogen & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 8, 2013	CPT Code 27447-22	$1,580.67	$0.00
	CPT Code 27447-22-AS	$107.48	$0.00
Total		$1,688.15	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1-Workers compensation state fee schedule adjustment.
   - 4063-Reimbursement is based on the physician fee schedule when a professional services was performed in the facility setting.
   - 593-The recommended allowance based on the value of surgical assistance performed by licensed non-physician.
   - 245-The service provided was greater than that usually required for the listed procedure.
   - OA-The amount adjusted is due to bundling or unbundling services.
   - B13-Previously paid. Payment for this claim/service may have been provided in a previous payment.
   - 247-A payment or denial has already been recommended for this service.
   - PI-There are adjustments initiated by the payer, for such reasons as billing errors or services that are not considered not reasonable or necessary. The amount adjusted is generally not the patient responsibility unless the workers compensation state law allows the patient to be billed.
   - W4-No additional reimbursement allowed after review of appeal/reconsideration/request for second review.
   - W3-Additional payment made on appeal/reconsideration.
   - 947-R03-Upheld-NO additional allowance has been recommended.

Issues

Is the requestor entitled to additional reimbursement?

Findings

28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

On the disputed date of service, the requestor billed CPT code 27447-22 and 27447-22-AS.

- CPT code 27447 defined as "Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)."
- The requestor appended modifier "22-Increased Procedural Services" defined as "When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required)" to the surgeon and assistant surgeon's bill.
- The requestor appended modifier "AS- Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery."

The issue in dispute is whether additional reimbursement is due because the requestor appended modifier "22."

The requestor contends that "**The surgeons did bill with the 22 modifier to indicate that the services they had provided were greater than that usually required for the listed procedure…*The physician has noted in the operative report that the modifier 22 was used because patient had an altered surgical field die to a significant valgus deformity with significant rotational abnormality. And the surgical procedure took over two times of the usual time amount required for this procedure*."**

No documentation was submitted to support assertion that "***the surgical procedure took over two times of the usual time."*** The requestor did not document nor does the requestor demonstrate how the services in dispute were more extensive in relation to similar knee surgery services. For the reasons stated, the Division finds that the requestor failed to support the use of modifier "22."

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	01/29/2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.